

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

1. WCB FILE NUMBER (if known):

1a. OSHA 300 CASE NUMBER (if applicable):

REASON FOR REPORT (check all that apply)

- 2a. ☐ LOST TIME - ONE OR MORE DAYS 2b. WAS EMPLOYEE PAID FOR ½ DAY OR MORE ON DAY OF INJURY? ☐ YES ☐ NO
3. ☐ LOST EARNINGS BUT NO LOST TIME 4. ☐ MEDICAL/HEALTH CARE 5. ☐ FATALITY DATE OF DEATH: ____/____/____
MM DD YYYY
- 6a. ☐ OCCUPATIONAL DISEASE 6b. DATE OF LAST EXPOSURE: ____/____/____
MM DD YYYY 6c. DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED: ____/____/____
MM DD YYYY
- 7a. ☐ CORRECT PRIOR REPORT 7b. DATE OF CORRECTION: ____/____/____
MM DD YYYY 7c. DATE CORRECTION SENT TO WCB: ____/____/____
MM DD YYYY

EMPLOYER

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| 8. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN): | | 9. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): | | 10. EMPLOYER NAME: | |
| 11. STREET/P.O BOX MAILING ADDRESS: | | 12. CITY: | 13. STATE: | 14. ZIP: | 15. TELEPHONE NUMBER: () |
| 16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED: | | 17. EMPLOYER LOCATION IF DIFFERENT FROM MAILING ADDRESS: | | 18. DID INJURY OR EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, THEN GIVE NAME AND PHYSICAL ADDRESS OF THE EMPLOYER WHERE THE EMPLOYEE WAS INJURED OR EXPOSED: | |

(check one) ☐ INSURER ☐ THIRD PARTY ADMINISTRATOR (TPA) ☒ SELF-ADMINISTERED EMPLOYER

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| 19. INSURANCE / TPA COMPANY NAME: MMA Workers Compensation Fund | | 20. POLICY NUMBER: | | 21. INSURER FILE NUMBER: | |
| 22. STREET/P.O. BOX MAILING ADDRESS: P.O. Box 9109 | | 23. CITY: Augusta | 24. STATE: ME | 25. ZIP: 04332-9109 | 26. TELEPHONE NUMBER: (207) 626-5583 |

EMPLOYEE

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| 27. LAST NAME: | | 28. FIRST NAME: | 29. MI: | 30. TELEPHONE NUMBER: () | 31. SOCIAL SECURITY NUMBER: | 32. GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE |
| 33. STREET/P.O. BOX MAILING ADDRESS: | | 34. CITY: | 35. STATE: | 36. ZIP: | 37. DATE OF BIRTH: ____/____/____ MM DD YYYY | |
| 38. OCCUPATION/JOB TITLE: | | 39. DATE OF HIRE: ____/____/____ MM DD YYYY | 40. WEEKLY WAGE AT TIME OF INJURY: \$ | | 41. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE NAME AND ADDRESS: | |

CLAIM INFORMATION

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| 42. DATE OF INJURY OR ILLNESS: ____/____/____ MM DD YYYY | | 43. DATE OF INCAPACITY: ____/____/____ MM DD YYYY | | 44. TIME EMPLOYEE BEGAN WORK (e.g. 7:30 a.m.): | | 45. DATE EMPLOYER NOTIFIED INSURER/TPA: ____/____/____ MM DD YYYY | |
| DATE EMPLOYER NOTIFIED: ____/____/____ MM DD YYYY | | DATE EMPLOYER NOTIFIED: ____/____/____ MM DD YYYY | | 46. TIME OF INJURY (e.g. 1:10 p.m.): | | 47. HAS EMPLOYEE RETURNED TO WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE DATE: ____/____/____ MM DD YYYY | |
| 48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatitis): | | 49. BODY PART(S) AFFECTED (e.g. lower right forearm): | | | | 50. ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN THE EVENT OCCURRED (e.g. acetylene torch, metal plate): | |

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| 51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT OCCURRED (e.g. cutting metal plate for flooring): | | 52. HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g. worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against hot metal.): | | | | | |
| WAS ACTIVITY PART OF NORMAL JOB DUTIES? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |

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| 53. HOSPITALIZED OVERNIGHT AS INPATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 54. WAS THE EMPLOYEE TREATED IN AN EMERGENCY ROOM? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 55. HEALTH CARE PROVIDER NAME: | | 56. MAILING ADDRESS: | | 57. TELEPHONE NUMBER: () | |
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PREPARER INFORMATION

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| 58. PREPARER NAME AND TITLE (TYPE OR PRINT): | | | 59. TELEPHONE NUMBER: () | | | 60. DATE SENT TO WCB: ____/____/____ MM DD YYYY | | |
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